31-008.08C Purchase of an Existing Facility: Unless there is a comprehensive appraisal by a Member of the Appraisal Institute (MAI), the Department uses the following guidelines to determine a reasonable allocation of the allowable basis to furniture and equipment for which "component" depreciation may be claimed.

Classification	Variable for Under 40 Beds	Basic Cost Bases For 40 to 75 Beds	Variable for Over 75 Beds
Moveable furniture	$1,000 per bed	$1,000 per bed	$1,000 per bed
Dietary equipment	2 1/2% decrease to "Basic" for each bed	$25,000	1% increase to "Basic" for each bed
Laundry equipment	"	$20,000	"
Heating equipment	"	$10,000	"
Air Cond. equipment	"	$10,000	"

31-008.08D Recapture of Depreciation: Depreciation in 471 NAC 31-008.08D refers to real property only. A long term care facility which is sold for a profit and has received NMAP payments for depreciation, shall refund to the Department the lower of -

1. The amount of depreciation allowed and paid by the Department between October 17, 1977, and the time of sale of the property; or
2. The product of the ratio of depreciation paid by the Department since October 17, 1977, to the total depreciation accumulated by the facility (adjusted to total allowable depreciation under the straight-line method, if any other method has been used) times the difference in the sale price of the property over the book value of the assets sold.

$$\frac{\text{Depreciation Paid by State}}{\text{Accumulated Depreciation}} \times \text{Sales Price - Book Value}$$

If the recapture of depreciation in any or all years before August 1, 1982, would have resulted in additional return on equity as allowed by the reimbursement plan then in effect, the amount of return on equity must be offset against the amount of recapture.

Examples:

	Data	
1.	Original Cost of Facility	$400,000
2.	Total Depreciation (S.L.) to date	$100,000
3.	Book Value of Facility (1-2)	$300,000
4.	Depreciation Paid Under Medicaid	$ 35,000
5.	Ratio of Depreciation Paid to Total Depreciation (4-2)	35%

Example A

Facility Sold For	$500,000
Difference in the Sale Price Over the Book Value	$200,000 ($500,000 - $300,000)
Medicaid Apportionment (35% X $200,000)	$70,000

The amount of depreciation recaptured on gain is $35,000, the amount of depreciation previously paid under NMAP.

Example B

Facility Sold For	$350,000
Difference in the Sales Price Over the Book Value	$ 50,000
Medicaid Apportionment (35% X $50,000)	$ 17,500

The amount of depreciation recaptured on gain is $17,500, which is the ratio of depreciation paid under NMAP for Medicaid clients ($35,000) to total depreciation accumulated ($100,000) times the amount of gain ($50,000) on the disposition of real property.

31-008.08E Other Gains and Losses on Disposition of Assets: Losses on the sale of real property are not recognized under NMAP. Losses on the disposal of replaced building components that have been specifically identified in the nursing facility's depreciation schedule since acquisition will be included in the allowable fixed cost for the report period. Gains/losses on personal property will be reduced from/included in allowable fixed costs for the report period. Gains in excess of the other allowable fixed costs will result in a negative fixed cost component of the facility's rate.

31-008.08F Sale or Transfer of Corporate Stock: Where the existing corporation continues after the sale or transfer of corporate stock, the depreciable basis of assets used under the program will be that of the then existing corporation. No revaluation of assets is allowed when only an acquisition of stock is involved.

31-008.09 Reporting Requirements and Record Retention: Providers shall submit cost and statistical data on Form FA-66, "Report of Long Term Care Facilities for Reimbursement" (see 471-000-41). Data must be compiled on the basis of generally accepted accounting principles and the accrual method of accounting for the report period. If conflicts occur between generally accepted accounting principles and requirements of this regulation, the requirements of this regulation shall prevail. Financial and statistical records for the period covered by the cost report must be accurate and sufficiently detailed to substantiate the data reported. All records must be readily available upon request by the Department for verification of the reported data. If records are not accurate, sufficiently detailed, or readily available, the Department may correct/reduce/eliminate data. Providers are notified of changes.

Each facility shall complete the required schedules and submit the original, signed Report to the Department within 90 days of the close of the reporting period, when a change in ownership or management occurs, or when terminated from participation in NMAP. Under extenuating circumstances, an extension not to exceed 15 days may be permitted. Requests for extensions must be made in writing before the date the cost report is due.

When a provider fails to file a cost report as due, the Department shall suspend payment. At the time the suspension is imposed, the Department shall send a letter informing the provider that if a cost report is not filed, all payments made since the end of the cost report period will be deemed overpayments. The provider shall maintain levels of care if the Department suspends payment.

If the provider takes no action to comply with the obligation, the Department may refer the case for legal action.

If a cost report has not been filed, the sum of the following is due:

1. All interim payments made during the rate period to which the cost report applies;
2. All interim payments made subsequent to the accounting rate period to which the cost report applies; and
3. Costs incurred by the Department in attempting to secure reports and payments.

If the provider later submits an acceptable cost report, the Department will undertake the necessary audit activities. Providers will receive all funds due them reflected under the properly submitted cost reports less any costs incurred by the Department as a result of late filing.

Providers shall retain financial records, supporting documents, statistical records, and all other pertinent records related to the cost report for a minimum of five years after the end of the report period or until an audit started within the five years is finalized, whichever is later. Records relating to the acquisition and disposal of fixed assets shall be retained for a minimum of five years after the assets are no longer in use by the provider. The Department shall retain all cost reports for at least five years after receipt from the provider.

Facilities which provide any services other than ICF/MR services shall report costs separately, based on separate cost center records. As an alternative to separate cost center records and for shared costs, the provider may use a reasonable allocation basis documented with the appropriate statistics. All allocation bases must be approved by the Department before the report period. Any Medicare certified facility shall not report costs for a level of care to the Department which have been reported for a different level of care on a Medicare cost report.

31-008.09A Disclosure of Cost Reports: Cost reports for all report periods ending October 30, 1990, or thereafter, are available for public inspection by making a written request to the Department of Social Services Audit Unit. The request must include the name (including an individual to contact), address, and telephone number of the individual or organization making the request; the facility name, location, and report period for the cost report requested; and directions for handling the request (review the reports at the Department's Central Office; pick up copies at the Department's Central Office; or mail copies). The total fee, $5.00 handling for each report requested and an additional $5.00 for each report to be copied and an additional $2.50 for each report to be mailed, must accompany the request. The facility will receive a copy of a request to inspect its cost report.

31-008.09B Descriptions of Form FA-66, "Long Term Care Cost Report": All providers participating in NMAP shall complete Form FA-66, consisting of Schedules "General Data," A (Parts 1 and 2), B (Parts 1, 2, 3, and 4), B-1, B-2, B-3, B-4, B-5, C, D, (Parts 1, 2, and 3), D-1, E (Parts 1 and 2), E-1, F (Parts 1 and 2) and "Certification by Officer, Owner, or Administrator." (See 471-000-41 (Note: This is an example of Form FA-66, "Long Term Care Cost Report") and 471-000-42 (Note: This is an example of Form FA-66MR, which contains supplemental information for ICF/MR's) for an example of all schedules.) For FA-66 must be completed in accordance with regulations found at 471 NAC 12-012 ff. Form FA-66 contains the following schedules, as described:

1. General Data: This schedule provides general information concerning the provider and its financial records.
2. Schedule A, Occupancy Data: This schedule summarizes the licensed capacity and inpatient days for all levels of care.
   Part 1 identifies the certified days available, and Part 2 identifies the inpatient census data of the facility. This data is used in determining the divisor in computing the facility's per diem rate.
3. Schedule B, Revenue and Costs: This schedule reports the revenues and costs incurred by the provider. The schedule begins with the facility's trial balance, and identifies revenue offsets, adjustments, and/or allocations necessary to arrive at the NMAP reimbursement costs of the ICF/MR level of care.

Part 1 identifies all revenues from patient services and any necessary offsets to costs from these revenues. Part 2 identifies other revenues realized by the facility and any necessary offsets to costs from these revenues. Part 3 identifies the facility's costs, summarizes the revenue offsets, summarizes the cost adjustments, and reports any necessary allocation of reimbursable costs. Part 4 summarizes the revenue and costs reported in parts 1, 2, and 3, and reports net income and identifies provision for income tax.

4. Schedule B-1, General Cost Allocation and Adjustment: This schedule is used when payroll costs and fringe benefits are not specifically identified by cost category on the facility's books. If the trial balance has these accounts identified to the appropriate category, this schedule is not used.
5. Schedule B-2, Transactions with Related Organizations - Report and Adjustments: This schedule identifies facility transactions which are expenditures for services and supplies furnished to the provider by organizations related to the provider by common ownership or control. Interest on loans, depreciation on fixed assets, and leases, with related organizations are reported on other schedules and are not reported on Schedule B-2.
6. Schedule B-3, Compensation of Owners, Directors and Other Related Parties - Report and Adjustment: This schedule identifies salaries/ wages/compensations paid or payable for managerial, administrative, professional, or other services, including amounts paid or payable which are for the personal benefit of the individual or are assets or services of the facility, and removes/reduces such amounts to amounts allowable for reimbursement. All such compensations must be reported even though removal/adjustment is not required.
7. Schedule B-4, Other Cost Adjustments: This schedule identifies all adjustments necessary to adjust costs to the proper category, or to adjust costs to amounts allowable for reimbursement which are not adjusted on other schedules of the report or which are not handled through allocations.
8. Schedule B-5, Statistical Data for Allocations: This schedule identifies the allocation basis used to allocate allowable costs between levels of care and the unallowable costs when direct cost accounting is not used or is impractical to use.
9. Schedule C, Comparative Balance Sheet: This schedule identifies the facility's balance sheet accounts for the previous year end and the current period. Multi-facility operations which maintain balance sheet accounts on a consolidated basis may make a statement to that effect on Schedule C; however, the long-term assets and liabilities sections must be completed for the reporting facility.

10. Schedule D, Depreciation Cost: This schedule identifies summary information on the fixed assets, necessary adjustments to depreciation, and allowable depreciation. Depreciation expense allowed under the NMAP may differ from that allowed for IRS purposes. Limitations may be imposed, and only the straight-line method may be used.
    Part 1 identifies data for all fixed assets included on the facility's trial balance, and any adjustments necessary to remove or adjust the assets for computation of reimbursable depreciation. Part 2 identifies all current report period fixed asset additions by line item. Part 3 identifies all current period fixed asset deletions by line item.
11. Schedule D-1, Depreciation Schedule Adjustments: This schedule identifies all adjustments needed to adjust the fixed asset value to amounts for reimbursement purposes.
12. Schedule E, Interest Cost: This schedule identifies loans, adjustments to loan balances, allowable interest expense and the interest expense limitation.
    Part 1 reports data for each loan on which interest is included on the trial balance, and any adjustments necessary to remove or adjust loans for reimbursement purposes. Part 2 computes the interest limitation adjustment necessary to limit loans to 80% of the cost of assets.
13. Schedule E-1, Loan Schedule Adjustments: This schedule identifies each adjustment needed to adjust the provider's trial balance loans to amounts used for reimbursement.
14. Schedule F, Leases: This schedule identifies items which are on long-term lease, and adjusts to actual costs of ownership when necessary.
    Part 1 reports data for each lease, including any necessary adjustment data.
    Part 2 reports the actual costs of the owner.
15. Certification of Officer, Owner, or Administrator; and Preparer Acknowledgement: This schedule attests to the accuracy of the cost report information provided to the Department; the provider is responsible for ensuring the accuracy even if the report is prepared by a third party. The statement must be signed by the owner, an officer, or the administrator of the facility, and must be acknowledged by the preparer as necessary.

31-008.10 Audits: The Department shall perform at least one desk audit and may perform subsequent desk audits and/or a periodic field audit of each cost report. Selection of subsequent desk audits and field audits will be made as determined necessary by the Department to maintain the integrity of the Nebraska Medical Assistance Program. The Department may retain an outside independent public accounting firm, licensed to do business in Nebraska or the state where the financial records are maintained, to perform the audits. Audit reports must be completed on all field audits and desk audits. All audit reports will be retained by the Department for at least three years following the completion and finalization of the audit.

An initial desk audit will be completed on all cost reports. Payment rates and care classification maximums are determined after the initial desk audit is completed. Subsequent desk and field audits will not result in a revision of care classification maximums.

All cost reports, including those previously desk audited but excluding those previously field audited, are subject to subsequent desk audits. The primary period(s) and subject(s) to be desk-audited are indicated in a notification letter sent to the provider to initiate a subsequent desk audit. The provider shall deliver copies of schedules, summaries, or other records requested by the Department as part of any desk audit.

All cost reports, including those previously desk-audited but excluding those previously field-audited, are subject to field audit by the Department. The primary period(s) to be field-audited are indicated in a confirmation letter, which is mailed to the facility before the start of the field work. A field audit may be expanded to include any period otherwise open for field audit. The scope of each field audit will be determined by the Department but must be sufficiently comprehensive to ascertain that the cost report complies with the provisions of this section. The provider shall deliver to the site of the field audit, or an alternative site agreed to by the provider and the Department, any records requested by the Department as part of a field audit.

The Department may not initiate an audit -

1. More than five years after the end of the report period; or
2. On a cost report which has been previously field-audited.

This does not preclude the Department from reopening an audit in accordance with 471 NAC 31-008.14 #1 or initiating an audit in response to a reopening in accordance with 471 NAC 31-008.14 #2 or when grounds exist to suspect that fraud or abuse has occurred.

31-008.11 Settlement and Rate Adjustments: When an audit has been completed on a cost report, the Department shall determine if an adjustment to the rate is required; if necessary, a settlement amount is determined. Payment or arrangements for payment of the settlement amount, by either the Department or the provider, must be made within 45 days of the settlement notice unless an administrative appeal filed within the appeal period is also filed within the 45-day repayment period. (See 471 NAC 31-009.16 for an exception to the 45-day repayment period.) Administrative appeals filed after the 45-day payment period will not stay repayment of the settlement amount. The filing of an administrative appeal will not stay repayments to the Department for audit adjustments not included in the appeal request. If an audit is completed during the applicable rate period, the Department shall adjust the rate for payments made after the audit completion.

The Department shall determine a final adjustment to the rate and settlement amount after the audit is final and all appeal options have been exhausted. Payment for any final settlement must be made within 30 days. If payment is not made, the Department shall immediately begin recovery from future facility payments until the amount due is recovered.

The Department shall report an overpayment to the federal government on the appropriate form no later than the second quarter following the quarter in which the overpayment was found.

31-008.12 Penalties: Under federal law, the penalty for making a false statement or misrepresentation of a material fact in any application for Medicaid payments and for soliciting, offering, or accepting kickbacks or bribes (including the rebate of a portion of a fee or charge for a patient referral) is imprisonment up to five years, a fine of $25,000, or both. Similarly, making a false statement of material fact about conditions or operations of any institution is a felony punishable by up to five years imprisonment, a fine of not more than $25,000, or both.

31-008.13 Appeal Process: Final administrative decision or inaction in the allowable cost determination process is subject to administrative appeal. The provider may request an appeal in writing from the Director of the Department within 90 days of the decision or inaction. The request for an appeal must include identification of the specific adjustments or determinations being appealed and basis and/or explanation of each item. See 471 NAC 2-003 and 465 NAC 2-006 for guidelines for appeals and fair hearings.

After the Director issues a determination in regard to the administrative appeal, the Department will notify the facility of the final settlement amount. Repayment of the settlement amount must be made within 30 days of the date of the letter of notification.

31-008.14 Administrative Finality: Administrative decision or inaction in the allowable cost determination process for any provider, which is otherwise final, may be reopened by the Department within three years of the date of notice of the decision or inaction.

"Reopening" means an action taken by the Director to reexamine or question the correctness of a determination or decision which is otherwise final. The Director is the sole authority in deciding whether to reopen. The action may be taken -

1. On the initiative of the Department within the three-year period;
2. In response to a written request from a provider or other entity within the three-year period. Whether the Director will reopen a determination, which is otherwise final, depends on whether new and material evidence has been submitted, a clear and obvious error has been made, or the determination is found to be inconsistent with the law, regulations and rulings, or general instructions; or
3. Any time fraud or abuse is suspected.

A provider does not have the right to appeal a finding by the Director that a reopening or correction of a determination or decision is not warranted.

31-008.15 Sanctions: Failure to comply with any repayment provisions will result in immediate suspension of payments as outlined in 471 NAC 2-002 ff., except that the Department is not required to give 30 days notice.

31-008.16 Change of Holder of Provider Agreement: A holder of a provider agreement receiving payments under this section must notify the Department 60 days prior to any change or termination regarding the holder of the provider agreement. If any known settlement is due the Department by that provider, payment must be made immediately. If the provider is subject to recapture of depreciation on the anticipated sale and/or if an audit is in process, the provider will be required to provide a guarantee of repayment of the Department's estimated settlement either by payment of that amount to the Department, providing evidence that another provider receiving payments under this section has assumed liability, or by surety bond for payment. All estimated or final amounts, regardless of appeal status, must be paid before the transfer of ownership.

The Department will not enter into a provider agreement with a new provider if there is an unpaid settlement payable to the Department by a prior provider of services at the same facility unless the new provider has assumed liability for the unpaid amount. Parties to a facility provider change may receive information about unpaid settlement amounts owed to the Department by making a written request.

12-014 Services for Long Term Care Clients with Special Needs

12-014.01 Definition: This category of clients includes those whose medical/nursing needs are complex or intensive and are above the level of capabilities of staff and above services ordinarily provided in a nursing facility. Clients in this category include, but are not limited to the following:

1. Ventilator-dependent clients;
2. Clients requiring specialized long-term rehabilitation; or
3. Other special needs clients.

12-014.01A Ventilator-Dependent Clients: These clients are dependent on mechanical ventilation to continue life and require intensive medical services/continual observation on an on-going basis. The facility shall provide 24-hour R.N. nursing coverage.

12-014.01A1 Criteria for Care: The client must -

1. Require intermittent (but not less than 12 hours in a 24-hour period) or continuous ventilator support. S/he is dependent on mechanical ventilation to sustain life, or is in the process of being weaned from mechanical ventilation;
2. Be medically stable;
3. Have care needs which require multi-disciplinary care (physician, nursing, respiratory therapist, etc.);
4. Require respiratory therapy staff and modality support (oxygen therapy, tracheostomy care, chest physiotherapy, etc.); and
5. Be unable to be cared for at home.

12-014.01B Clients Requiring Specialized Long-Term Rehabilitation: These clients must require and be capable of participating in an extended rehabilitation program. Their care must be -

1. Complex medically with rehabilitative needs; or
2. The rehabilitative needs must be in combinations that exceed the criteria of the nursing facility level of care as defined in 471 NAC 12-002 ff.